Orange Advanced Medical
3414 W. Union Hills, Suite 13
Phoenix Az 85027
Phone 623-581-0051

Comprehensive Health History Form

Patient Information

Patient Name: _____
(last) *(first)* *(middle initial)*

Address: _____

City: _____ State _____ Zip _____

Home Ph: (_____) _____ Cell Ph: (_____) _____

Work Ph: (_____) _____ Best Contact: Phone Text Email

Email: _____ Sex: M or F

SS#: _____ DOB: _____ Age: _____

Status: □ Single □ Married □Widowed □Divorced □Separated □Minor

Occupation: _____

Employer: _____

In Case of Emergency

Name: _____ Relationship _____

Home Ph: (_____) _____ Cell Ph: (_____) _____

How Did You Hear About Us?

□ Referral: _____ □ Direct Mail
□ Internet □ Magazine
□ TV □ Other: _____

What specific condition prompted you to choose us for your healthcare needs?

_____

_____

Accident Information

Do you currently have an active accident claim? □ Yes □ No Date _____

Type of Accident: □ Auto □ Work □ Home □ Other _____

To whom have you made a report of your accident?
□ Auto Insurance □ Employer □ Work Comp □ Other _____

Attorney Name: (*if applicable*)
_____

Primary Care

Primary Care Physician's Name _____

Clinic Name _____ Phone Number _____

I allow my health progression to be shared with my primary care physician:

□ Yes □ No

Do you have current X-rays at another office or clinic?

□ Yes □ No

Insurance Information

Who is responsible for this account? □ Self □ Other: _____

If other, what is the relationship to patient: _____

Insurance Company: _____

Policy #: _____ Group #: _____

Is the patient covered by additional Insurance? □ Yes □ No

Subscribers Name:

_____

DOB: _____ SS#: _____

Relationship to Patient:

Assignment and Release

I understand and agree that (regardless of whatever health or medical benefits I have), **I am ultimately responsible to pay Orange Advanced Medical, the balance due on my account for any professional services rendered and for any supplies, tests or medications provided**.

I hereby authorize payment of any health insurance or medical plan benefits directly to **Orange Advanced Medical,** for medical services rendered and for any supplies, tests or medications provided.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to **Orange Advanced Medical,** all rights to payments and benefits and all legal and other health plan that I (or my child, spouse, or minor dependent) may have under my/our applicable health plan(s) or health insurance policy(ies).

This assignment includes, but not limited to, a designation that **Orange Advanced Medical,** can act on my/our behalf, as our representative or ERISA representative, as to any initial claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to COMPANY, as a result of services rendered by **Orange Advanced Medical,** and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer.

This assignment and designation remain in effect unless revoked in writing, and a photocopy is to be considered as valid and enforceable as the original.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Print Name of Patient, Parent, Guardian or Personal Representative

Current Medications

Medication **Dosage/How Long** **Condition**

_____

_____

_____

_____

_____

_____

_____

Medication Allergies: _____

Supplement Allergies: _____

Food Allergies: _____

Do you have any surgical devices in your body? (*ie screws, pins, plates, etc)*

□ Yes □ No If yes, where located

Current Herbal Medications

Medication **Dosage/How Long** **Medical Condition**

_____

_____

_____

Other Medications

Please List Previous Medications (Last 10 Years)

Medication **Dosage/How Long** **Medical Condition**

_____

_____

_____

Have your medications or supplements ever caused you unusual side effects or problems? □ Yes □ No Describe: _____

_____

Have you had prolonged or regular use of:

NSAIDS (Advil, Aleve, etc.), Motrin or Aspirin? □ Yes □ No

Tylenol? □ Yes □ No

Acid Blocking Drugs (Tagament, Zantac, Prilosec)? □ Yes □ No

Frequent Antibiotics (> 3 times a year) □ Yes □ No

Long Term Antibiotics □ Yes □ No

Steroids Present or Past (Prednisone, Nasal Allergy Inhalers) □ Yes □ No

Current Condition

List current and ongoing Problems in Order of Severity:

Problem and Onset_____

□ Mild □ Moderate □ Severe

How was this treated in the past? _____

How successful was your treatment: □ Excellent □ Good □ Fair

Problem and Onset_____

□ Mild □ Moderate □ Severe

How was this treated in the past? _____

How successful was your treatment: □ Excellent □ Good □ Fair

Problem and Onset_____

□ Mild □ Moderate □ Severe

Has it occurred before? □ Yes □ No When? _____

Is the condition getting worse? □ Yes □ No □ Unknown

Is the Condition: □ Auto Related □ Job Related □ Home Injury

□ Slip/Fall □ Lifting □ Slept Wrong □ Unknown Cause

□ Other _____

Rate the severity of your pain from 1 (least pain) to 10 (severe pain) _____

How often do you have this pain? _____

Does it interfere with: □ Work □ Sleep □ Daily Routine □ Recreation

What treatment have your received for your condition?

□ Medication _____

□ Surgery (year) _____

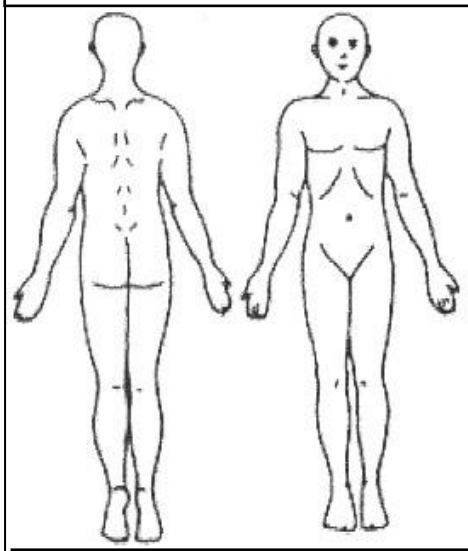
□ Physical Therapy

□ Chiropractic Services □ None □ Other _____

How successful was your treatment: □ Excellent □ Good □ Fair

What do you hope to achieve in your visit with us? _____

_____



Label on the Diagram the CURRENT Areas of Discomfort:

A= Aching
B= Burning
C= Cramps
D= Dull
N= Numbness
P= Pins & Needles
S= Stabbing
SH= Sharp
ST= Stiffness
SW= Swelling
T= Tingling

Patient Name _____ Date of Birth _____ Date_____

Lifestyle History

Check Your Exercise Levels:

□ **Inactive** □ **Light Activity** □ **Moderate Activity**

□ **Heavy Activity** □ **Vigorous Activity**

Please check all that apply:

□ Tobacco – Type _____ Amt/Day: _____

Are you exposed to 2nd hand smoke regularly? _____

□ Alcohol Drinks/Week: _____

□ Coffee/Caffeine Drinks Cups/Day: _____

Do you currently or have previously used recreational drugs? □ Yes □ No

If yes, what types/method (IV, inhaled, smoked, etc) _____

_____

Work Activity

Labor Activity:

□ Light □ Moderate □ Heavy □ Sedentary

Work Activity Postures:

□ Bending □ Climbing □ Kneeling □ Pulling
□ Pushing □ Reaching □ Sitting □ Standing
□ Twisting □ Walking □ Computer □ Repetitive

Work Activity Level:

□ Full-Time □ Part-Time □ Homemaker □ Student □ Unemployed
Hours per week _____ Mostly □ Sitting □ Walking □ Standing

Work Environment:

□ Difficult □ Enjoyable □ Relaxed □ Stressful

Daily Activities

Effects of Current Condition on Daily Performance
Please mark for each CURRENT Condition:
1=No Effect
2=Slightly Limited
3=Limited
4=Mostly Limited
5=Unable to Perform

Bending	1 2 3 4 5
Carrying	1 2 3 4 5
Climbing	1 2 3 4 5
Concentrating	1 2 3 4 5
Computer Work	1 2 3 4 5
Dancing	1 2 3 4 5
Doing Chores	1 2 3 4 5
Dressing	1 2 3 4 5
Driving	1 2 3 4 5
Gardening	1 2 3 4 5
Jumping	1 2 3 4 5
Lifting	1 2 3 4 5
Playing Sports	1 2 3 4 5
Pushing	1 2 3 4 5
Reading	1 2 3 4 5
Rolling Over	1 2 3 4 5
Sexual Activity	1 2 3 4 5
Shoveling	1 2 3 4 5
Sitting	1 2 3 4 5
Sitting to Standing	1 2 3 4 5
Sleeping	1 2 3 4 5
Standing	1 2 3 4 5
Walking	1 2 3 4 5
Watching	1 2 3 4 5
Working	1 2 3 4 5

Health History Please check all that apply (past or present) / Circle **CURRENT** Conditions

___ ADD
___ AIDS/HIV
___ Alcoholism
___ Allergies
___Alzheimer's
___ Anemia
___ Anorexia
___ Appendicitis
___ Arthritis
___ Asthma
___ Atopic Dermatitis
___ Bed Wetting
___ Bleeding Disorders
___ Blood Clot
___ Bronchitis
___ Bulimia
___ Cancer
___ Cataracts
___ Cerebral Palsy
___ Chemical Dependency
___ Chest Pain
___ Chicken Pox
___ Chronic Fatigue Syndrome
___ Crohn's/Colitis
___ Constipation
___ CVA (Stroke)
___ Cystic Kidney Disease
___ Depression
___ Diabetes
___ Ear Infections
___ Eating Disorder
___ Eczema
___ Emphysema
___ Epilepsy/Convulsions
___ Eye Problems
___ Fibromyalgia
___ Fractures
___ Gallbladder Disorder
___ Gallstones
___ Glaucoma
___ Goiter
___ Gonorrhea
___ Gout
___ Headaches
___ Heart Attack
___ Heart Disease
___ Heart Failure
___ Hepatitis
___ Hernia
___ Herniated Disk
___ Herpes/Lesions/Shingles
___ High Blood Pressure
___ High Cholesterol
___ Hormone Replacement
___ Hypertension
___ Hypoglycemic
___ Influenza Pneumonia
___ IBS (*Irritable Bowel Syndrome*)
___ Jaundice
___ Kidney Stones
___ Liver Disease
___ Lung Disease
___ Lupus Erythema (*Discoid*)
___ Lupus Erythema (Systemic)
___ Malaria
___ Measles
___ Migraine Headaches
___ Multiple Sclerosis
___ Mumps
___ Osteoporosis
___ Pacemaker
___ Parkinson's disease
___ Pinched Nerve
___ Pneumonia
___ Pregnancy
___ Prostate Problems
___ Prosthesis
___ Psoriasis
___ Rheumatoid Arthritis
___ Rheumatic Fever
___ Scarlet Fever
___ Scoliosis
___ Seizure Disorder
___ Sickle Cell Anemia
___ Sinusitis
___ Sleep Apnea
___ Spina Bifida
___ STD
___ Stroke
___ Suicide Attempt(s)
___ Swelling Feet
___ Thyroid Problems
___ Tonsillitis
___ Tuberculosis
___ Tumors, Growths
___ Typhoid Fever
___ Ulcers
___ Vertigo
___ Other: _____

Patient Name _____ Date of Birth _____ Date_____

Review of Systems

Ears/Nose
Decreased Hearing □ Yes □ No
Ear Drainage □ Yes □ No
Ear Pain/Ear Infection □ Yes □ No
Frequent Sneezing □ Yes □ No
Headaches □ Yes □ No
Hay fever □ Yes □ No
Itchy/Watery Eyes □ Yes □ No
Loss of Smell □ Yes □ No
Nose Bleeds □ Yes □ No
Nose Drainage/Runny □ Yes □ No
Ringing in Ears □ Yes □ No
Snoring □ Yes □ No
Stuffy Nose □ Yes □ No
TMJ □ Yes □ No

Eyes/Vision
Blurred/Double Vision □ Yes □ No
Cataracts □ Yes □ No
Eye Pain □ Yes □ No
Field Cuts □ Yes □ No
Glaucoma □ Yes □ No
Itching □ Yes □ No
Photophobia □ Yes □ No
Tearing □ Yes □ No
Wear Glasses/Contacts □ Yes □ No

Skin
Excessive Sweating □ Yes □ No
Eczema □ Yes □ No
Dryness □ Yes □ No
Hives □ Yes □ No
Itching □ Yes □ No
Lumps □ Yes □ No
Nail Texture/
Skin Color Changes □ Yes □ No
Rashes □ Yes □ No
Skin Lesions □ Yes □ No
Varicosities □ Yes □ No

Cardiovascular
Angina □ Yes □ No
Chest Pain □ Yes □ No
Leg pain/ache □ Yes □ No
Congestive Heart Failure □ Yes □ No
Coronary Artery Disease □ Yes □ No
Difficulty Breathing Lying □ Yes □ No
Heart Murmur □ Yes □ No
Heart Problems □ Yes □ No
High Blood Press □ Yes □ No
Low Blood Pressure □ Yes □ No
Pacemaker/Defibrillator □ Yes □ No
Palpitations □ Yes □ No
Shortness of Breath □ Yes □ No
with Exertion/Exercise □ Yes □ No
Swelling of Legs □ Yes □ No
Ulcers □ Yes □ No
Varicose Veins □ Yes □ No
Waking at Night □ Yes □ No
Shortness of Breath □ Yes □ No

Muscular/Skeletal
Ankle/Foot Pain □ Yes □ No
Arthritis □ Yes □ No
Balance Problems □ Yes □ No
Elbow Pain □ Yes □ No
Fibromyalgia □ Yes □ No
Hip Pain □ Yes □ No
Joint Pain □ Yes □ No
Knee Pain □ Yes □ No
Low Back Pain □ Yes □ No
Muscle Aches □ Yes □ No
Muscle Cramping
Muscle Stiffness (in a.m.)
Neck Pain □ Yes □ No
Pain Between Shoulder □ Yes □ No
Pain Wakens You □ Yes □ No
Shoulder Pain □ Yes □ No
Weakness in Arms/Legs □ Yes □ No
Wrist/Hand Pain □ Yes □ No

Gastrointestinal
Abdominal Pain/Cramps □ Yes □ No
Abnormal Stool □ Yes □ No
Belching □ Yes □ No
Black/Tarry Stools □ Yes □ No
Bloating/Gas □ Yes □ No
Change in Appetite □ Yes □ No
Change in Bowel Habit □ Yes □ No
Constipation □ Yes □ No
Crohn's Disease □ Yes □ No
Diarrhea □ Yes □ No
Hemorrhoids □ Yes □ No
Indigestion □ Yes □ No
Jaundice □ Yes □ No
Rectal Bleeding □ Yes □ No
Reflux/Heartburn □ Yes □ No
Nausea/Vomiting □ Yes □ No
Vomiting Blood □ Yes □ No

Throat/Respiratory
Asthma/ Wheezing □ Yes □ No
Bleeding Gums □ Yes □ No
Chronic Cough □ Yes □ No
Coughing up Blood □ Yes □ No
Chest Congestion □ Yes □ No
Dentures □ Yes □ No
Difficulty Swallowing □ Yes □ No
Hoarseness □ Yes □ No
Shortness of Breath □ Yes □ No
Sore Throat □ Yes □ No

Hematologic
Anemia □ Yes □ No
Bleed easily □ Yes □ No
Blood Clotting □ Yes □ No
Bruise Easily □ Yes □ No
Lymph Node Swelling □ Yes □ No

Neurological
Dizziness □ Yes □ No
Facial/Limb Weakness □ Yes □ No
Fainting/
Loss of Consciousness □ Yes □ No
Headaches □ Yes □ No
Loss of Memory □ Yes □ No
Migraines □ Yes □ No
Numbness □ Yes □ No
Seizures □ Yes □ No
Sleep Disturbance □ Yes □ No
Slurred Speech □ Yes □ No
Stroke □ Yes □ No
Tingling □ Yes □ No
Tremor □ Yes □ No
Unsteadiness of Gait □ Yes □ No

Mental/Emotional
Anxiety/Panic □ Yes □ No
Behavioral Change □ Yes □ No
Bi-Polar Disorder □ Yes □ No
Blackouts/Amnesia □ Yes □ No
Clumsy □ Yes □ No
Confusion □ Yes □ No
Cry Often □ Yes □ No
Daytime Sleepiness □ Yes □ No
Convulsions □ Yes □ No
Depression □ Yes □ No
Emotional Numbness □ Yes □ No
Foggy Thinking □ Yes □ No
Forgetfulness □ Yes □ No
Hallucinations □ Yes □ No
Overused Alcohol □ Yes □ No
Hyperactive □ Yes □ No
Insecure □ Yes □ No
Insomnia □ Yes □ No
Jittery □ Yes □ No
Memory Loss □ Yes □ No
Mood Swings/Irritability □ Yes □ No
Nervous Breakdown □ Yes □ No
Grumpiness □ Yes □ No
Poor Concentration □ Yes □ No
Restless Leg Syndrome □ Yes □ No
Uses Tranquilizers □ Yes □ No
Workaholic □ Yes □ No

Urinary
Blood in Urine □ Yes □ No
Burning or Pain □ Yes □ No
Frequency □ Yes □ No
Incontinence □ Yes □ No
Kidney Stone □ Yes □ No
Urgency □ Yes □ No

Endocrine
Abnormal Urination □ Yes □ No
Change in Appetite □ Yes □ No
Decreased Endurance □ Yes □ No
Diabetes □ Yes □ No
Excessive Hunger □ Yes □ No
Excessive Thirst □ Yes □ No
Fatigue/Drowsiness □ Yes □ No
Feel "Burned Out" □ Yes □ No
Goiter □ Yes □ No
Hair Loss/Hair Growth □ Yes □ No
Hot Flashes/Night Sweats □ Yes □ No
Hypo/Hyper Thyroid □ Yes □ No
Inability to Lose Weight □ Yes □ No
Poor Sleep □ Yes □ No
Voice Changes □ Yes □ No
Weight Loss/Gain □ Yes □ No

Reproductive
Burning Urination □ Yes □ No
Cramps □ Yes □ No
Frequent Urination □ Yes □ No
Hormone Therapy □ Yes □ No
Itching/Rash □ Yes □ No
Decreased Libido □ Yes □ No
Mood Swings □ Yes □ No
Infertility

Males Only:
Prostate problems □ Yes □ No
Erectile Dysfunction □ Yes □ No
Genital Pain □ Yes □ No
Hernia □ Yes □ No
Impotence □ Yes □ No
Urination at Night □ Yes □ No
Prostate Enlargement □ Yes □ No
Prostate Infection □ Yes □ No

Females Only:
Heavy Bleeding □ Yes □ No
Hot Flashes □ Yes □ No
Irregular Menstruation □ Yes □ No
Ovarian Cysts □ Yes □ No
Painful Periods □ Yes □ No

Notes:

_____
_____
_____
_____
_____
_____
_____

Patient Name _____ Date of Birth _____ Date_____

Medical

Surgeries (Type and year)

_____ _____
_____ _____
_____ _____

Injuries

___ Back Injury _____ ___ Broken Bones/Fractures _____
___ Head Injury _____ ___ Industrial _____
___ Neck Injury _____ ___ Severe Fall _____
___ Soft Tissue _____ ___ Other _____

FAMILY HISTORY

Check all family members that apply	Mother	Father	Brother (s)	Sister (s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age (if still alive)												
Age at Death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (ex: Rheumatoid Psoriatic)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Disease (ex: Lupus, Hashimotos)												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse (such as Alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												
Other:												

Patient Name _____ Date of Birth _____ Date_____